		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038679

Facility Name: Park Haven Care Center

Address: 107 S. Lincoln (Number) Smithton (City) 62285 (Zip Code)

County: St. Clair

Telephone Number: (618) 235-4600 **Fax #** (618) 235-5829

IDPA ID Number: 95-2301514017

Date of Initial License for Current Owners: 12/31/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Elizabeth Ogdon **Telephone Number:** (877) 823-8375 ext 4369

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 03/29/02 (Date)
(Type or Print Name) Greg Swartz
(Title) Director of Financial Services

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	101	Intermediate (ICF)	101	36,865	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	30,059	1,155		31,214	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,059	1,155		31,214	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.67%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/31/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary United Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	110,566	7,951	3,556	122,073		122,073	1,341	123,414			1
2	Food Purchase		100,835		100,835		100,835	(3,839)	96,996			2
3	Housekeeping	46,200	7,272	20,633	74,105		74,105	(90)	74,015			3
4	Laundry	28,506	10,167	12,732	51,405		51,405		51,405			4
5	Heat and Other Utilities			77,710	77,710		77,710	(5,462)	72,248			5
6	Maintenance	16,708	8,263	39,618	64,589	(931)	63,658	(616)	63,042			6
7	Other (specify):*											7
8	**TOTAL General Services**	201,980	134,488	154,249	490,717	(931)	489,786	(8,666)	481,120			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	675,109	30,751	27,884	733,744		733,744	7,326	741,070			10
10a	Therapy		34		34		34		34			10a
11	Activities	43,249	5,108		48,357		48,357	1,682	50,039			11
12	Social Services	114,543	1,916		116,459		116,459	1,447	117,906			12
13	Nurse Aide Training					2,597	2,597		2,597			13
14	Program Transportation			1,724	1,724		1,724	49	1,773			14
15	Other (specify):*	543			543		543		543			15
16	**TOTAL Health Care and Programs**	833,444	37,809	33,208	904,461	2,597	907,058	10,504	917,562			16
	C. General Administration											
17	Administrative					55,064	55,064		55,064			17
18	Directors Fees											18
19	Professional Services			5,292	5,292		5,292	(3,363)	1,929			19
20	Dues, Fees, Subscriptions & Promotions			22,543	22,543		22,543	(618)	21,925			20
21	Clerical & General Office Expenses	95,909	8,724	213,805	318,438	(54,072)	264,366	42,446	306,812			21
22	Employee Benefits & Payroll Taxes			183,288	183,288		183,288	(16,266)	167,022			22
23	Inservice Training & Education			(7,072)	(7,072)	(2,597)	(9,669)		(9,669)			23
24	Travel and Seminar			3,102	3,102		3,102	235	3,337			24
25	Other Admin. Staff Transportation							235	235			25
26	Insurance-Prop.Liab.Malpractice			48,992	48,992		48,992	13,583	62,575			26
27	Other (specify):*			1,023	1,023		1,023	(446)	577			27
28	**TOTAL General Administration**	95,909	8,724	470,973	575,606	(1,605)	574,001	35,806	609,807			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,131,333	181,021	658,430	1,970,784	61	1,970,845	37,644	2,008,489			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Park Haven Care Center #0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			34,155	34,155		34,155	5,490	39,645			30
31	Amortization of Pre-Op. & Org.			5,768	5,768		5,768		5,768			31
32	Interest			71	71		71	499	570			32
33	Real Estate Taxes			45,811	45,811		45,811		45,811			33
34	Rent-Facility & Grounds			238,531	238,531		238,531	(24,624)	213,907			34
35	Rent-Equipment & Vehicles			23,455	23,455		23,455	184	23,639			35
36	Other (specify):*											36
37	**TOTAL Ownership**			347,791	347,791		347,791	(18,451)	329,340			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61	61	(61)		54,206	54,206			42
43	Other (specify):*		1,256	2,712	3,968		3,968		3,968			43
44	**TOTAL Special Cost Centers**		1,256	2,773	4,029	(61)	3,968	54,206	58,174			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,131,333	182,277	1,008,994	2,322,604		2,322,604	73,399	2,396,003			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,691)	L-2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,849)	L-21		24
25	Fund Raising, Advertising and Promotional	(439)	L-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(446)			28
29	Other-Attach Schedule	(27,752)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (38,177)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	64,044	Various	34
35	Other- Attach Schedule	47,297	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 111,341		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 73,164		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Park Haven Care Center

ID# 0038679

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	UR FEES	$ 0	10	1
2	BARBER & BEAUTY	0	40	2
3	PATIENT PERSONAL NEEDS	0	43	3
4	VENDOR SERVICE CHARGES	(879)	21	4
5	BANK SERVICE CHARGES	(310)	21	5
6	PAC FEES	(485)	20	6
7	MAGICAL MOMENTS	0	27	7
8	ADDITIONAL RENT	(24,624)	34	8
9	YELLOW PAGES	(446)	27	9
10	CORPORATE COLLECTION FEES	(1,008)	21	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(27,752)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(444)	1,785	0	0	0	0	0	0	0	0	0	1,341	1
2	Food Purchase	(3,839)	0	0	0	0	0	0	0	0	0	0	(3,839)	2
3	Housekeeping	(90)	0	0	0	0	0	0	0	0	0	0	(90)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,462)	0	0	0	0	0	0	0	0	0	0	(5,462)	5
6	Maintenance	(616)	0	0	0	0	0	0	0	0	0	0	(616)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,451)	1,785	0	0	0	0	0	0	0	0	0	(8,666)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(382)	7,708	0	0	0	0	0	0	0	0	0	7,326	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	315	1,367	0	0	0	0	0	0	0	0	0	1,682	11
12	Social Services	1,447	0	0	0	0	0	0	0	0	0	0	1,447	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	49	0	0	0	0	0	0	0	0	0	0	49	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	1,429	9,075	0	0	0	0	0	0	0	0	0	10,504	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,363)	0	0	0	0	0	0	0	0	0	0	(3,363)	19
20	Fees, Subscriptions & Promotions	(618)	0	0	0	0	0	0	0	0	0	0	(618)	20
21	Clerical & General Office Expenses	(10,738)	53,184	0	0	0	0	0	0	0	0	0	42,446	21
22	Employee Benefits & Payroll Taxes	(16,266)	0	0	0	0	0	0	0	0	0	0	(16,266)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	235	0	0	0	0	0	0	0	0	0	0	235	25
26	Insurance-Prop.Liab.Malpractice	13,583	0	0	0	0	0	0	0	0	0	0	13,583	26
27	Other (specify):*	(446)	0	0	0	0	0	0	0	0	0	0	(446)	27
28	**TOTAL General Administration**	(17,613)	53,184	0	0	0	0	0	0	0	0	0	35,571	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,635)	64,044	0	0	0	0	0	0	0	0	0	37,409	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Park Haven Care Center** **#** **0038679** **Report Period Beginning:** **01/01/01** **Ending:** **12/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	5,490	0	0	0	0	0	0	0	0	0	0	5,490	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	499	0	0	0	0	0	0	0	0	0	0	499	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(24,624)	0	0	0	0	0	0	0	0	0	0	(24,624)	34
35	Rent-Equipment & Vehicles	184	0	0	0	0	0	0	0	0	0	0	184	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(18,451)	0	0	0	0	0	0	0	0	0	0	(18,451)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	54,206	0	0	0	0	0	0	0	0	0	0	54,206	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	54,206	0	0	0	0	0	0	0	0	0	0	54,206	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,120	64,044	0	0	0	0	0	0	0	0	0	73,164	45

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Beverly Health & Rehabilitation	100	Over 400 facilities throughout the US				
Services, Inc. (Owns 100% of Beverly						
Enterprises - Illinois, Inc.)						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Home Office Costs	$ 197,165	Beverly Enterprises - Illinois, Inc.	100.00%	$ 250,349	$ 53,184	1
2	V	11	Social Services Consultant		Beverly Enterprises - Illinois, Inc.	100.00%	1,367	1,367	2
3	V	10	Nursing Consultant	19,140	Beverly Enterprises - Illinois, Inc.	100.00%	26,848	7,708	3
4	V	1	Dietary Consultant		Beverly Enterprises - Illinois, Inc.	100.00%	1,785	1,785	4
5	V	3	Housekeeping Consultant		Beverly Enterprises - Illinois, Inc.	100.00%			5
6	V	10	Nursing Consultant		Beverly Enterprises - Illinois, Inc.	100.00%			6
7	V	6	Maintenance Consulting		Beverly Enterprises - Illinois, Inc.	100.00%			7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 216,305			$ 280,349	$ * 64,044	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Beverly Health & Rehab Services, Inc.
Street Address: One Thousand Beverly Way
City / State / Zip Code: Fort Smith, AR 72919
Phone Number: (479) 201-2000
Fax Number: (479) 201-4302

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Corporate HO Cost & QA	Resident Days	90,747	3	$ 583,015	$ 333,426	31,214	$ 200,538	1
2	21	Regional Cost & QA	Resident Days	90,747	3	144,814	3,823	31,214	49,811	2
3										3
4	11	Corporate HO Cost & QA	Resident Days	90,747	3	3,975	3,149	31,214	1,367	4
5	11	Regional Cost & QA	Resident Days	90,747	3	0	0	31,214	0	5
6										6
7	10	Corporate HO Cost & QA	Resident Days	90,747	3	17,242	3,584	31,214	5,931	7
8	10	Regional Cost & QA	Resident Days	90,747	3	60,810		31,214	20,917	8
9										9
10	1	Corporate HO Cost & QA	Resident Days	90,747	3	5,190	4,048	31,214	1,785	10
11	1	Regional Cost & QA	Resident Days	90,747	3	0	0	31,214	0	11
12										12
13	3	Corporate HO Cost & QA	Resident Days	90,747	3	0	0	31,214	0	13
14	3	Regional Cost & QA	Resident Days	90,747	3	0	0	31,214	0	14
15										15
16	10	Corporate HO Cost & QA	Medicare Days	4,465	3	0	0	0	0	16
17	10	Regional Cost & QA	Medicare Days	4,465	3	0	0	0	0	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 815,046	$ 348,030		$ 280,349	25

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4	CCA Financial		X	Acquistion of Equipment	See capital lease agreement						570	4
5	(Turbolan Lease)											5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 570	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 570	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	21,275	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	42,505	2
3. Under or (over) accrual (line 2 minus line 1).	$	21,230	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	24,101	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	45,811	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	33,687	8
1997	38,032	9
1998	38,209	10
1999	39,397	11
2000	42,505	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Haven Care Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0038679

CONTACT PERSON REGARDING THIS REPORT Elizabeth Ogdon

TELEPHONE (877) 823-8375 ext. 4369 FAX #: (479) 201-4301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	133301130043	Park Haven Care Center	$ 42,504.70	$ 42,504.70
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 42,504.70	$ 42,504.70

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,282 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1985	$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1985		$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1993	52,443	4,353	5-20	4,353		44,681	9
10	(See depreciation schedule for detail of items)			1994	27,057	569	5-15	569		24,524	10
11				1995	13,241	805	5-20	805		6,652	11
12				1996	2,711	198	10-15	198		1,021	12
13				1997	100,410	8,927	10-15	8,927		39,476	13
14				1998	21,341	1,363	5-20	1,363		4,618	14
15				1999	8,584	895	5-15	895		2,241	15
16				2000	8,561	605	5-15	605		916	16
17				2001	63,250	3,127	10	3,127		3,128	17
18											18
19	Computer & Related Equipment			1994	7,751		5			7,751	19
20				1995	1,071		5			1,071	20
21				1996	8,330	10	5-7	10		8,330	21
22				1998	11,445	2,252	5	2,252		8,553	22
23				2000	644	135	5	135		259	23
24											24
25	Software Development Cost			1990	1,055		5			1,055	25
26				1991	7,237		5			7,237	26
27				1994	4,339		5			4,339	27
28				1996	1,394		5			1,394	28
29				1997	833	125	5	125		833	29
30				1998	9,462	3,159	10	3,159		4,919	30
31				1999	34,343	2,507	10	2,507		12,259	31
32				2000	4,402	318	10	318		439	32
33				2001		5,148	5	5,148		6,136	33
34											34
35	Computer & Related Equipment			1999	813	162		162		352	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 390,717	$ 34,658		$ 34,658	$	$ 192,184	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 109,384	$ 10,517	$ 10,517	$	5-10	$ 51,742	71
72	Current Year Purchases	3,493	238	238		5-10	238	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 112,877	$ 10,755	$ 10,755	$		$ 51,980	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 503,594	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 45,413	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 45,413	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 244,163	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Building Construction	$ 1,226	92
93			93
94			94
95		$ 1,226	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Encore Retirement Centers, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		101	12/31/85	$ 213,907	4	5	3
4	Additions							4
5								5
6								6
7	TOTAL		101		$ 213,907 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: Purch of all fac from Encore *

10. Effective dates of current rental agreement:
Beginning 01/01/1998
Ending 12/31/2001

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ 0
13.	/2003	$ 0
14.	/2004	$ 0

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 19,071 Description: See next page for schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	96 Ford Windstar	$ 381.00	$ 4,568	17
18					18
19					19
20					20
21	TOTAL		$ 381.00	$ 4,568	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 90

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 42

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 400	$ 1,552	$	$ 1,952
2	Books and Supplies	100	295		395
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests	50	200		250
9	TOTALS	$ 550	$ 2,047	$	$ 2,597
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,597			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	7

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Park Haven Care Center # 0038679 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,963	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,116)	479,839		3
4	Supply Inventory (priced at)	39,944		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	764		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 524,510	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	391,943		15
16	Equipment, at Historical Cost	112,877		16
17	Accumulated Depreciation (book methods)	(244,163)		17
18	Deferred Charges	30		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 260,687	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 785,197	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (18,213)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,360		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,186		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,101		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Garnishment w/held & Conting	(3,800)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 65,634	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany	(79,887)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (79,887)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (14,253)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 799,450	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 785,197	$	48

***(See instructions.)**

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 729,381	1	
2	Restatements (describe):		2	
3	**Remove Prior year adj-home office & dist center equity**	326,623	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,056,004	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	30,727	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)	(287,281)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (256,554)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 799,450	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,408,466	1
2	Discounts and Allowances for all Levels	(58,826)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,349,640	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,679	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,679	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net Vending, Patient Personal, Other Misc	1,012	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,012	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,353,331	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	490,717	31
32	Health Care	904,461	32
33	General Administration	575,606	33
	B. Capital Expense		
34	Ownership	347,791	34
	C. Ancillary Expense		
35	Special Cost Centers	(50,177)	35
36	Provider Participation Fee	54,206	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,322,604	40
41	**Income before Income Taxes (line 30 minus line 40)****	30,727	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 30,727	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,977	2,185	$ 43,197	$ 19.77	1
2	Assistant Director of Nursing	1,443	1,725	31,223	18.10	2
3	Registered Nurses	7,169	8,051	155,304	19.29	3
4	Licensed Practical Nurses	11,152	12,418	164,787	13.27	4
5	Nurse Aides & Orderlies	36,626	38,760	287,050	7.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,365	1,401	11,236	8.02	9
10	Activity Assistants	3,721	4,064	26,700	6.57	10
11	Social Service Workers	8,030	9,118	105,951	11.62	11
12	Dietician	11,982	12,898	86,675	6.72	12
13	Food Service Supervisor	1,991	2,304	25,690	11.15	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,726	1,885	18,643	9.89	17
18	Housekeepers	6,806	7,276	49,186	6.76	18
19	Laundry	4,451	4,853	30,865	6.36	19
20	Administrator	1,952	2,080	55,058	26.47	20
21	Assistant Administrator					21
22	Other Administrative	2,002	2,237	16,778	7.50	22
23	Office Manager	2,058	2,283	22,990	10.07	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,451	113,538	$ 1,131,333 *	$ 9.96	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 3,556	I-1,3	35
36	Medical Director		3,600	I-9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant		165	I-10,3	38
39	Pharmacist Consultant		5,454	I-10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 12,775		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melvin Zimmerman	Executive Director	0	$ 55,064
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,064

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Stratton, Giganti, Stone, & Kopec	Legal Fees/Consult	$ 1,929
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,929

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,924
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	60,155
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Injury	
Payroll Taxes	95,718
Retirement Expense	816
Employee Fringe Benefits	2,589
Workers' Comp Ins Adjust	(17,411)
Medical/Dental Adjust	1,231
Rounding	
TOTAL (agree to Schedule V, line 22, col.8)	$ 167,022

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 735
Advertising: Employee Recruitment	20,618
Health Care Worker Background Check	
(Indicate # of checks performed 0)	1,057
Dues & Subscriptions	
Advertising & Public Relations	439
Community Education	
Less: PAC Fees	(485)
Less: Public Relations Expense	( )
Non-allowable advertising	(439)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,925

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,295
Meals	42
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,337

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Park Haven Care Center # 0038679 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $4842**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **Various**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **280** Line **10, Col. 2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,206**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **n/a** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,679**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **35%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernst & Young** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not available until later in the year**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.